POTTSGROVE RECREATION

AUTHORIZATIONFORMEDICATION ADMINISTRATION

Date of Birth: _____

Child's Full Name:_____ Grade: _____

Allergies: _____

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PHYSICIAN REQUEST

Name of Prescribed Medication: _____

Reason: _____ Dose: _____

Route: _____ Time to be given at camp: _____

Side Effects: _____

Medication to be administered as follows:

1. _____ as needed, daily.
2. _____ INHALERS ONLY (Student may carry and self administer 6-9 grade only)
3. _____INHALERS ONLY (Students k-5 grade camp counselor will hold medication and provide to student when needed).
4. _____ EPIPEN (Camp counselor will hold in case of an emergency and administer if needed).
5. _____ Asthma Emergency Plan needed (Physician to provide)
6. _____ Epipen/Allergic Reaction Emergency Plan needed (Physician to provide)

_____ _____

Physician Signature Printed Name

_____ _____

Date Phone Number

PARENT REQUEST

I, the parent of _____ request that the employees (director, counselor, or designee) of the Pottsgrove Recreation administer the above named medication as prescribed by my child's physician. My signature on this document constitutes a complete waiver of liability claim in any and all respects against the Pottsgrove Recreation and its' Board of Directors and all its' employees unless negligence is proven with regard to any claim for injury in connection with dispensation of the prescribed medication.

Additionally, I agree to provide the medication to Pottsgrove Recreation staff in the original pharmacy or manufacturer labeled container. I also accept responsibility to provide a physician's note and my written instructions if the medication is to be changed or discontinued. I give permission for Pottsgrove Recreation and physician to communicate regarding this medication/medical condition.

_____ _____

DATE SIGNATURE OF PARENT/GUARDIAN